



Categorisation and micro-rationing: access to care in a French Emergency Department

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Abstract:

This paper describes how the categorisation of patients by staff in a French emergency department (ED) leads to the micro-rationing of care. Although ED staff are reluctant to acknowledge it, they refuse to treat many would-be patients at the reception stage, and advise them to go to other care settings (such as general practitioners' premises or social dispensaries). The study analyses the judgmental categories staff use to decide patients' eligibility for care, paying particular attention to their clinical, organisational, moral and social dimensions. Staff ration care at the point of service delivery but they soften the harshness of the rationing by making a positive discrimination in favour of those seen to be in real need. Data from observations and interviews are used to analyse the tensions between the different models of 'local justice' employed by doctors.

Keywords:

Emergency department, health professions, access to care, rationing, justice, public service ethos, categorisation

There is a considerable health sociology literature on patient categorisation by health care personnel. It has been shown that staff, acting collectively, construct typified patient profiles and subsequently evaluate presenting persons according to certain expected categories. But while there are many accounts of categorisation in action, the rationing of care at the micro-level has been neglected. With a few exceptions (Griffiths and Hughes 1994, Timmermans 1999), sociologists have not linked the two concepts. This is partly because interest in micro-level rationing is relatively new, and partly because health sociologists have paid insufficient attention to the practical consequences of categorisation for patient care outcomes. A re-reading of the patient categorisation literature shows that many patients subjected to negative judgements and pejorative labelling also experienced delays in treatment or denial of access to care (two of the basic forms of health care rationing). Patient categorisation leads first, to the formulation of a particular definition of the case, and second, to socially discriminative practices towards the presenting patient concerned. Both the quantity and the quality of care given to such patients may be diminished.

If one accepts this linkage between categorisation and rationing, it follows that the latter can be based on many of the factors documented in the categorisation literature. Rationing may depend on perceptions of the condition for which treatment is sought. Thus it has been argued that some conditions are considered as less worthy of care than others, for instance terminal conditions (Glaser and Strauss, 1965), psychiatric disorders (Jeffery 1979, Roth 1972) and strokes (Hoffmann 1974). By contrast, other clinical features, such as those

which constitute the 'interesting case' relevant to medical training, 'mobilize' staff action so that patients gain quicker and more extensive care (Jeffery 1979, Dodier and Camus 1998, Sudnow 1967).

Rationing can also rest on judgements about personal or social character. Patients with similar physical conditions, but perceived differences of other kinds, may experience differential access to care. Often this will affect individuals who are seen as having low social worth. It has been reported that older people receive fewer resuscitative attempts than younger patients with similar conditions (Sudnow 1967, 1973, Timmermans 1999). Studies also show that persons whose way of life, personal history or putative social class are morally disvalued, like tramps, 'drunks', and drug addicts (Jeffery 1979, Mannon 1976, Roth 1972, Sudnow 1967) are given less, or less good, care. The financial status of the patient, his/her type of employment, his/her insurance protection, or his/her use of private-practice doctors are also stressed by Roth (1972) as factors which affect the quality of the care given. Evaluations of patient behaviour in the immediate face-to-face situation can also result in delay or denial of care. Patients who were perceived as unco-operative or over-complaining received less attention in the surgical unit studied by Lorber (1975) and in the psychiatric ward studied by May and Kelly (1982).

As shown in these examples, we should be alert to the possibility that rationing may take a variety of forms, including delay in offering care, a lower ranking in a queue for treatment, less time with hospital staff, the direction of the patient to other less desirable treatment facilities and the direct denial of treatment. The aim of this paper is to explore the implementation of these last two, most clear-cut forms of rationing in a French emergency department (ED). In the hospital as well as in other human service settings, staff tend to modify the intake processes via which clients enter organisations (Hughes, 1971). Staff members act as gatekeepers who control what they see as inappropriate demands for services. They decide whether the incoming person can access the services or not, and if so, his or her rank of priority. EDs are a particularly interesting place for those who want to observe health rationing in action. They are organisations that can be accessed by patients drawn from the entire population, and which lack any single agreed definition about what constitutes an emergency case (Wolcott 1979). The constant increase in ED attendances, particularly in France (circa +5% per year), brings ED staff into contact with greater numbers of presenting patients whose conditions are seen as inappropriate for emergency treatment.

Roth and Douglas (1972, 1983), in their study of five North American EDs, provide many examples where patients were turned away without treatment. Staff made judgements about the social worth of patients, taking into account such attributes as age, race, sex, behaviour, mode of dress, language and accent. Persons of lower status were more likely to be turned away than others. In the three British EDs studied by Jeffery (1979), staff did not

refuse to treat patients but sometimes varied the quality and quantity of care (waiting time, comprehensiveness of the clinical examination, hostile attitudes) according to the perceived characteristics of the case. Those seen as tramps, 'drunks', drug users, or persons having 'self-inflicted' conditions were negatively evaluated. In another British ED studied by Hughes (1989) few patients were refused access, but one category sometimes turned away were 'regulars' returning to seek further treatment for 'old' injuries after an initial visit a few days before. Dodier and Camus (1998) provide another perspective on these issues, based on their study of a French ED. They take issue with the view that the imputation of low social status leads automatically to a reduction in the quality or quantity of a patient's care. The patients thus labelled aroused complex reactions, which ranged from highly negative attitudes to a real 'mobilization' of resources in their favour. Treatment of these cases was dependent on circumstances (particular flow of patients at the time), and on individual staff attitudes. This study raises the important question of whether past studies oversimplify the picture when they suggest that lower social class attenders are the group most likely to be denied access to care.

Previous ED studies leave many questions unanswered. First, it is unclear what precise roles staff from different occupational groups (doctors, nurses and clerks) play in patient categorization and how their actions are co-ordinated. One hypothesis is that doctors play a crucial role in framing the rules of patient eligibility, but delegate the implementation of these rules to nurses and reception staff. Hughes (1989) raises the question of the margin of discretion of the gatekeeper, another issue requiring further research. His work suggests that lower ranking staff (like clerks) commonly accept the overturning of their decisions by higher ranking staff (such as doctors) without demur, but it is not clear if this is a general phenomenon. Another question is whether patients can influence the judgement given on them. As was noticed by Kelly and May (1982), categorisation is often analysed with a structural and static approach; not with an interactionist one. It is generally considered that the categorisation criteria are fixed before the patient arrives on the scene, and that the label s/he is given is not negotiable. But it is not certain whether patients, more generally, accept such a passive role in their evaluation. Finally we still need to know more about how staff weigh the various factors that may contribute to decisions: what happens when there is a contradiction between different criteria, and whether one criteria have overwhelming determinative power?

Generally speaking, sociological studies pay little attention to either specific, local features of EDs, such as unique organisational characteristics of a hospital, or the wider social and political context. A study such as this one, which systematically interviewed all categories of staff, allows for a more detailed investigation of the moral principles used in categorising and prioritising patients. It then becomes possible to consider whether there is a consensus about these principles. The supplementation of the interviews with field observations made it possible to examine the 'rules' in action, including the way they are communicated and elaborated through staff members' accounting practices. The analysis that follows pays particular attention to staff notions of ethical work practice and their solidification into what might be called models of 'local justice', as developed by Elster and Herpin (1992). Even

though the allocation mechanisms described by these authors (in the field of organ transplants) are more formal and codified than categorisation in the ED there are many similar features.

The concept of the decision-making process in an organisational context (Crozier 1963, Crozier and Friedberg, 1977) has been adopted as an appropriate theoretical framework for understanding the intake process in the ED (see: Vassy, 1999, for another application of the approach). The 'strategic analysis of organisations' indicates that such decision-making processes depend on a set of informal rules, and associated norms and values. The characteristics of these rules depend on power relationships within the organisation.

Methods and data sources

The data presented in the paper were gathered in the ED of an 850-bedded French general hospital, which provided general, acute, obstetric and geriatric services. Activity levels in the medical and surgical units of the hospital, including the ED, were increasing. But, because costs exceed revenue, the hospital budget was in deficit. The hospital is located in a deprived Parisian suburb. There is a large immigrant population and the unemployment rate is high. The research was carried out in 1998, when approximately 30,000 patients received treatment in the ED studied.

The study was a part of a larger research project concerned with the way ED staff manage socially-disadvantaged patients (Fassin 1999). Fieldwork was carried out over a period of 4 months. It involved semi-structured interviews and field observations, which were conducted after negotiations with both the Hospital General Manager and the consultant in charge of the ED. Most of the staff of the unit were interviewed (doctors (n=10), nurses (n=11), auxiliaries (n=7) and ward clerks (n= 3)). Interviews lasted between 45 minutes and one hour and a half. They were not tape-recorded. They were, as far as was possible, recorded contemporaneously in full, as usually done amongst the sociologists of the strategic analysis of organisations. Additionally, many spontaneous extended interview-conversations were completed. Data were also generated through the analysis of organisational documents. Observations centred on the reception function and were recorded in the form of field notes. The processing of patients was observed at various times of day and night. My research role was one of a non participant observer. The resultant corpus of data was analysed, using an inductive approach of the kind employed in many field studies. The researcher gradually comes to discover significant classes of persons and events, their properties and their linkages, until all his presumed classes are displaced by those based upon observations and interviews (Schatzman and Strauss, 1973).

'Re-directing' patients and rationing care

ED staff refuse to treat many would-be patients at the reception stage. In the language of the setting, this is usually presented as 're-directing' patients to other care settings. At interview staff argue that this does not constitute denial of care because they send the patient to another care setting. Indeed when the patient is directed to a specialised unit in another hospital (i.e. dental ED) it is difficult to argue that staff are rationing care, because they do not have the competence to provide it. Rather, rationing takes place when the staff refuse to provide a service which they could competently provide, and when the re-directed person does not obtain the equivalent service elsewhere. However, the latter situation may arise when the re-directed patient does not follow instructions to go to another care setting, when the care offered in that setting is not equivalent (for instance it is more expensive), or when the request for care is also refused there. When the re-direction is to the independent GPs, the risk of denial of care is high, as many patients are deterred by the cost of the consultation and as some GPs will not accept payment with vouchers for free care. In France patients can visit any doctor they choose to see, either in a hospital outpatient clinic or in a "liberal" practice. "Liberal" doctors are independent practitioners, be they GPs or specialists. Initially the patient pays the bill in full (1). A percentage of the bill is then reimbursed by the state social insurance scheme, which covers almost all the population. The balance can be reimbursed by a private insurance scheme if the patient has coverage.

The control of appropriate service utilisation implies rationing of care in this ED. Building on Parker (1975 quoted by Klein, Day and Redmayne 1996), ED staff often engage in rationing by deflection: they protect their own resources by dumping the problem in the lap of other carers. The aim of this paper is to identify the actors who make decisions at the reception stage, and to analyse the judgmental categories used to determine patient eligibility for care. These categories have four dimensions: clinical, organisational, moral, and social.

Use of clinical criteria to categorise patients

At the reception station, ED staff make a first clinical judgement about patients in interpreting signs such as the location of pain, duration and intensity of pain, and its possible origin. Using these criteria, staff distinguish between 'real emergencies' and 'non-urgent cases', which are often described in pejorative terms such as 'outpatients' and 'people who have a pain' ('personnes qui ont des bobos').

(a) *Reception clerks.* The first person that most patients meet in the ED is the reception clerk. After having answered a few questions, patients are invited to give their name and address, to present their social insurance card and to wait in a waiting room near the reception station. The clerk registers this information in a computer and prints it on a sheet of paper. This

information will be used by the hospital Finance Department to bill patients many months later. The sheets are also used by the nurses, who routinely read them as they come through from the treatment areas to collect patients to see the doctor.

In order to typify the case, reception clerks tend to ask a set of routine questions. What is the patient's problem? Does the problem result from a shock? (if the answer is yes, the problem is considered as a surgical case and the person is referred to the ED surgeons). Does the person have a referral letter from his GP? (if the answer is yes, he is immediately registered). How long has the problem been present? According to the answers given, the clerk may register the attending person or advise him/her to go to another specialised ED (paediatrics ED, dental ED in another hospital etc), or to a hospital outpatient clinic to be examined by a specialist doctor (usually an ophthalmologist or an ENT specialist). When the clerk thinks the problem is neither a matter for the ED, nor for the outpatient clinics, she asks a nurse or a sister, who sometimes calls a doctor for advice.

The reception clerks, who have low social and professional status (2), complain about the difficulties of their work. There are no written guidelines, no formalised rules. They have no clinical training and must learn the job through their contact with other more experienced reception clerks or nurses. At the same time they must acquire the clinical knowledge needed to determine patients' eligibility to care, their order of precedence and their pathways through the unit.

'At the beginning, it was not easy, I could hardly cope. It was explained to me: 'If it is a back pain, if the person comes on his own, he is for us (the medical sector of the ED). If the person has fallen, he is for surgery.' I told them: 'I can't ask all these questions to people, I am no doctor'. They told me: 'Of course, you can! You must dare to do it!' (clerk - interview)

Sometimes clerks make mistakes in the categorisation process: they confuse what is a matter for surgery with a matter for medicine, or they fail to recognise the clinical seriousness of a case and its urgency. According to a general rule, patients must be processed in the order in which they arrive. But where a patient's condition seems serious, nurses demand that the reception clerk put their sheet on top of the pile, or at least mentions the case to them. They also want clerks to guide the most urgent cases straight through into the unit. If reception clerks fail to do this, they are reprimanded by nurses and doctors, something they feel is particularly unfair. For instance, the reception clerk had given no special priority to a man who said that he suffered tummy ache. Doctors discovered later that he had an epigastric pain and that he was having an infarction. Conversely, the clerk may be criticised for giving high priority to a trivial case.

The clerk's responsibilities *vis-à-vis* patients and the rest of the department are considerable. This confirms findings from classic studies in organisational sociology which demonstrate the crucial role played by subordinates in bureaucratic settings (Crozier 1963, Mechanic 1962), or by 'lay persons' in medical care units (Strauss et al. 1963). As Hughes (1989) has put it, the casualty reception clerk uses clinical categories to typify 'would-be patients'. She has no clinical expertise but she is strongly influenced by the professional culture of doctors and nurses, who delegate to her the gatekeeper role and the responsibility for prioritising patients. But many differences distinguish the British ED studied by Hughes (1989) from the French one. In the latter the clerks feel that they are not supported enough by the rest of the staff and many quit this job as soon as possible. The lack of experienced reception clerks and the greater concern to deny care to ineligible patients care in this department, in comparison with the British one, mean that other staff members become more involved in the process of categorising patients at the reception station.

(b) *Nurses*. The consultant who heads the Department acknowledges the importance of the reception clerk role, although he remains unaware that informal patient categorisation sometimes implies the denial of care. He has introduced a policy that nurses should assist at the reception station, but has not introduced any formal training scheme. In practice, because of limited staff numbers, there are long periods where no nurse is present behind the desk. Moreover nurses dislike undertaking this task, which they find unrewarding. Like the clerks, they have received no specific training, and the job is not clearly defined. Typically, the clerk calls a nurse when she believes one is needed. Nurses acknowledge that they work 'each one in her own way': the only informal rule is to call the doctor when in doubt or when the patient refuses to be 're-directed' elsewhere. Some doctors question nurses' abilities to screen attenders, and take the view that only they should make decisions to re-direct patients. But other clinicians recognise that nurses must be involved in patient categorisation, delegate this role to them and intervene only if the would-be patient insists on seeing a doctor.

'It is not for the nurse to make the decision whether the patient should be admitted here or not. Doing a diagnosis with only a few elements is difficult. It is even more difficult for a nurse. (...) When the nurse is embarrassed, she goes looking for a doctor.' (doctor A - interview)

'It is the reception nurse who usually tells them (the attending persons) that their problem is not so serious. The guy says: 'Yeah, I want to see the doctor !' The doctor comes and says the same thing. Nurses sometimes make a boob, but it's rare.' (doctor B - interview)

In categorising patients, the nurse starts with much the same questions as the reception clerk. What is the problem you came for? For how long has it lasted? How did it happen? But she then asks more precise clinical questions to get additional information about the symptoms and the possible origins of the problem. Depending on the information received, the nurse has number of options. She may authorise the clerk to register the attending person,

she may advise that person to consult a doctor in another hospital setting (specialised ED, outpatients clinics with an immediate or postponed appointment), or she may call a doctor to get him to persuade the person to consult an outside doctor (GP, psychological care centre, people's dispensary, etc.).

One of the main criteria used by nurses to determine patients' eligibility for care is the duration of the problem. Most staff operate on the basis that if the problem lasts for more than a few days, they consider that it is not an emergency condition. For instance, a reception nurse tried to convince a man in his fifties talking with a Hispanic accent to go to consult a GP. This man said he had back pain from a work accident which happened one month ago. He argued that he did not want to see a GP because this doctor would send him to the pharmacist and to the (independent) radiologist. It would take him time and money. The nurse called a doctor who denied him care and advised him to see a GP.

(c) *Doctors*. Several ED doctors, including the senior consultant and his deputy, consider that only 15 to 20 per cent of attenders are 'real emergencies' or 'really urgent cases'. Whatever their professional status and length of service (3), all ED doctors agree that cases like this, which involve a risk to life, have a legitimate claim to treatment. They quote serious asthma, cardiac infarction, acute lung oedema and multiple-injuries as examples. They also emphasise the need to examine patients who present unclear symptoms where diagnosis is uncertain but potentially grave, for example: headache, thoracic pain and abdominal pain. At interview they all eventually discuss 'outpatients', namely patients presenting with minor health problems, which are not appropriate for the ED. However, they differ in the opinions about whether all cases of this kind warrant clinical examination.

The senior consultant and his deputy both maintain that every person attending the department is examined by a doctor. They explain that it is impossible to know if the patient has a serious condition without examining him as part of a detailed consultation, and underline their medical and legal accountability. The other practitioners can be divided into two groups. In the language of the setting, the 'broad ones' examine every attending person, or most of them. In their opinion, the public hospital as an institution has a responsibility to provide care to all those who need it. They also underline the risk of medical mistakes if the provisional diagnosis made at the reception station is wrong. They give numerous instances of the difficulties in using these clinical criteria, at first glance, without examining the patient.

Conversely the 'firm ones' re-direct most attenders whose cases seem to be trivial. They feel that, if the health problem is minor or has lasted for a few days, the attender can wait a few hours more to access the health care system via a different route. A 'firm' doctor denied care to a man in his thirties, who suffered insomnia. This attender explained that he

had not slept well for three months, mentioning his work on the nightshift and some family problems. He also mentioned that he had been helped out a few times in this ED and that he would like to have tranquillisers. The doctor told him to go and see a GP in his local area, who would refer him, if necessary, to a Psychological Care Centre.

The ‘firm’ doctors assert that if staff treat attenders with minor conditions, they risk not having enough time and human resources to diagnose and treat patients with serious health problems. Other complex arguments are presented. The main argument relates to what is best for the patients in the long run: to get disadvantaged patients into the habit of coming to the ED is not good for them; they would be better off looking for a doctor in a health care setting who can provide both initial treatment and continuing care. What is at stake is to educate the patients as to how they should use the health system. Other arguments are related to the division of labour in the health care system: free care in ED amounts to unfair competition with independent GPs located in the same area. Moreover the real cost to the social insurance scheme of hospital care for a benign pathology is higher than the cost in most community-based health care settings.

Doctors acknowledge that their practices differ and that there is little prospect of change for the moment.

‘Some doctors think that they can educate the clientele: “This is an outpatient case” and they turn it away to the GP. I myself am much less firm. Behaviours are not consistent. (...) The doctor’s personality plays a big role. Some of them open the umbrella, as we say in our jargon, and some of them say: “This is an outpatient case, and the Outpatients Clinic will send him back to us if this is grave.”’ (doctor A – interview)

These disagreements within the medical team are well known to other staff, from the reception clerks and auxiliaries to the nursing sister. Staff explain that ‘you have to adapt yourself to the psychology of each doctor’. When the doctor in charge is a ‘broad’ one, receptionists and nurses register all attending persons. When he is a ‘firm’ doctor, staff generally call him to see the most contentious cases, but also appear to exercise more discretion in re-directing minor cases to other agencies or independent GPs. Different doctors fall along a continuum from the ‘broadest’ to the ‘firmest’. But even ‘broad doctors’ may exceptionally be firm with an attender and vice-versa. Doctors distinguish between legitimate and illegitimate attenders, using criteria that are not exclusively clinical.

Use of organisational criteria to categorise patients

These criteria are not related to the attributes of the presenting patient, but to the characteristics of the unit at the time of attendance. Depending on the number of patients present in the waiting room, the reception clerk may re-direct more or less attenders to other care settings.

‘We decide whether to register her or him (an attender presenting with a minor health problem), depending on the physical state of the patient, depending on the staff workload or on the length of the queue’. (sister – interview)

Other factors specific to the organisation of this hospital play a role in the registration decision. For example, because the on-call psychiatrist arrives only in the evening and is not available during the day, patients with suspected psychiatric disorders (such as the one mentioned above) are often redirected elsewhere. Similarly, the extent of co-operation between the ED and different hospital outpatient clinics is an important consideration. Outpatient clinic staff will say over the telephone whether appointment slots are available for patients who could be re-directed to them. If no appointments are available the case is likely to be processed in the ED. In certain clinics, like ENT, staff rarely offer appointments. As a consequence, the reception clerks register more patients with the type of pathology referred to such clinics compared with conditions treatable in clinics where appointments are available.

Additionally, as Roth (1972, 1983) suggests, the general organisation of the national health care system plays a role. The day and the time of patient arrival determines whether re-direction is possible or not, depending on the availability of other health professionals and facilities. For example, hospital outpatient clinics are open only on weekdays from 9.00 am to 4.00 p.m. During the evening and at the weekend, emergency staff only rarely re-direct patients, and during the night they never do.

Use of moral criteria to categorise patients

Just as described by Roth (1972, 1983), ED staff express moral judgements about people attending the department. In the French ED, these moral evaluations can influence the registration decision, the order of precedence amongst patients, and staff behaviour towards them. In this article, I have space to document only two forms of evaluation which may influence the registration decisions – concerned with staff perceptions that patients use the unit for their own ‘convenience’ and must respect previous instructions.

When patients present with conditions that staff consider trivial, and openly state that they have come to the ED because it is more convenient than other health care settings, they are very likely to be re-directed elsewhere. ED staff are unanimous in rejecting the idea that the hospital is merely the provider of a technical service, offering quicker treatments and more convenient opening hours than other health care settings. The case of a patient with the 'industrial injury' mentioned above illustrates the negative reaction incurred by patients who are perceived to be making demands on the service for their own convenience. A further example, is that reception clerks have been instructed to re-direct persons who come to the ED to get a second medical opinion, after having consulted another doctor for the same condition.

Staff also express disapproval of patients who fail to follow instructions about return visits to the hospital. Patients who return frequently to the ED seeking treatment for minor conditions break an unwritten rule about the proper demands they can make. In the example of the attender with insomnia, the doctor on duty justified his decision to deny care by underlining the fact that the patient had mentioned several previous visits to the department. This argument worked against him. The doctor considered that he had to redirect the patient for his own good. Another rule, which is explicit, forbids patients to come back for a number of specific treatments, such as changing bandages, removing sutures, and checking plaster casts. ED staff re-direct persons needing these services to the outpatients clinics.

Use of social criteria to categorise patients

ED staff have constructed an informal system for rationing care for patients with minor ailments. However, they attenuate the rationing according to the attender's social situation.

(a) *Lack of knowledge of the health care system.* ED staff routinely attempt to assess the extent to which individual patients are acquainted with the French care system. They want to know whether the attending patient possesses the cognitive, psychological and linguistic resources that will enable him/her to identify an alternative source of care and to explain his/her health problems. If staff think that the patient is unable to do so, they are more likely to allow registration in the ED. They often assume that foreigners have an inadequate knowledge of the system.

“There are always cases where a reception nurse catches somebody who has not got proper social security. This person does not speak French well, looks completely lost and has not been in France for long. I register these people without even asking the doctor. It is our job to do this. If the doctor asks me: ‘why did you register this woman?’ I reply: ‘because this is our job!’” (nurse – interview)

A reception clerk or nurse noticing a patient’s lack of familiarity with the health care system may be influenced in favour of registration. However, this will not be seen as sufficient grounds in all cases. In cases where a patient is re-directed, the effects of denying immediate treatment can be softened. For instance, the nurse may telephone the doctor in charge of the service to which the patient has been referred to make the appointment.

(b) *Recognisable social problems.* Staff often make judgements about the economic resources of patients. Presuming that the patient is poor is conducive to registration. Members of staff recognise that those experiencing social problems probably lack the resources to pay an independent GP.

‘We try to convince attending persons suffering minor ailments to go and see a GP, except in some cases where we have to see them against our will. This happens during weekends and with people suffering from deprivation. They tell us “Yes, you are right, but I do not have enough to pay.”’ (doctor C – interview)

The most extreme case is that of the homeless people. This is the type of case that staff immediately mention when asked about people so disadvantaged that they may have no other access to medical care. Staff assert that a number of homeless people attend the emergency service on a regular basis, if only to have an opportunity to eat and sleep. The homeless people who attend the service are not re-directed.

ED staff assess presenting patients on multiple dimensions, which often point in the same direction. Thus a patient has little familiarity with the health care system, who is seen to be poor and has social problems (such as isolation or family difficulties) is more likely to be registered. A ‘broad’ doctor agreed to see a thirty year old who had ‘flu’, on the basis that he was living on his own, worked as a cleaner, did not speak French fluently and had missed his appointment at the social dispensary. Similarly, a nurse registered a woman who said she had been coughing for two weeks and then mentioned domestic violence problems.

Members of staff do sometimes re-direct individuals seen to have social problems. However, they usually take this factor into account when choosing the health services to

which these individuals are re-directed, mostly social dispensaries. The nurse may also smooth the way for the patient by making a call to arrange the appointment with a dispensary or a GP.

(c) *Having no family doctor.* ED staff consider whether the would-be patient has a family doctor or not. They assume that it is relatively easy for patients with a GP to gain access to an alternative source of care and are likely to steer them in that direction. Those who have no GP may get a more sympathetic reception. However, the ‘firmer’ doctors refuse to consider this issue. As shown in the example of the patient requesting tranquillisers, they seek to discourage patients from acquiring the ‘habit’ of attending emergency services for minor health problems. In many such cases, re-directing the patient means advising him/her to look for a GP in his/her area, who will become his/her family doctor.

‘People are re-directed toward a GP only when we are confident that they can afford to go there. They tell us that they “don’t know anybody”. We tell them that this is precisely the time where they should attempt to get to know somebody. This is not denying care, it is rather educating the patient.’ (doctor B – interview)

(d) *The lack of social security entitlements.* The hospital Finance Director has instructed administrative and health care staff to ask patients to present a social security card as soon as they arrive in the ED. If they do not have one, they should present an identity card. However, as confirmed by my observations, the consensus among the staff is that the absence of social security entitlements, or documents entitling the individual to stay in France, should not preclude the registration of patients. It is a fact that the clerks ask for a social security card or, if the patient does not have one, an identity card. They nevertheless register the patients even if they cannot produce these documents. In such cases the registration details are based on the information given orally by the patients.

Many staff see this as a positive reflection of their social obligations. They strenuously denounce other hospitals and clinics in the area, which deny access to care on the basis of such criteria. They suggest that lack of social security entitlements in this ED may help justify registration, even when the condition is relatively trivial. This contrasts with the attitude taken to patients who have the correct social security documents, and who could go elsewhere.

Discussion and conclusion

In this ED some staff perceive the rationing of care as a strategy for coping with growing demand in the context of limited human resources. As they interact together they elaborate informal rules concerning the eligibility and priority of patients for treatment in the ED. Their decision making cannot be analysed as a purely bureaucratic process, based on the application of procedural rules. Neither can it be analysed as a typical street level bureaucracy in which staff interpret the existing protocols, since no written procedures exist in this ED. The law states that all attenders must be seen, but it does not specify the nature of the clinical assessment (4).

The paper has described the various criteria used by ED staff to categorise patients, and the way they combine these criteria, using the approach developed by Elster and Herpin (Elster 1992, Elster and Herpin 1992). The clinical criterion is always given priority in deciding whether or not to register a patient. Attenders with minor health problems are likely to be redirected at the reception station. But other criteria may also come into play.

As found in earlier ED studies, organisational and moral criteria are also taken into account in the decisions concerning the registration of patients. Staff re-direct patients to other health care settings only during normal opening hours (not in the evening, night, weekend) and only when there is a queue in the ward. Often they arrive at a negative moral judgement on the attenders, openly stating that they have come to the ED because it is more convenient for them or saying that they want a second medical opinion. If, in addition, the patient has a minor condition, he or she is likely to be turned away.

Finally, judgements about patients' eligibility are influenced by assessments of their social situation. Staff tend to follow an informal rule according to which they accept persons with social problems or lack of knowledge of the health system, whatever the clinical seriousness of their condition. In effect, they have set up an informal system of positive discrimination (5). By doing so, they construct a noble image of themselves as caring public servants. These data are at odds with Roth and Jeffery's findings, which indicate that staff favoured patients seen as having high social value. There are several possible explanations for these different findings. First, they may be related to differences in the socio-economic background of the countries and periods studied (Dodier and Camus, 1998). In the French ED, staff members try to construct the meaning of their work as a response to the consequences of the perceived economic and social crisis of the late 1990s. Second, this general hospital is located in a deprived Parisian suburb and lacks the prestige of teaching hospitals. Some doctors who work in this ED originate from deprived immigrant backgrounds. They may feel closer to disadvantaged patients than to those from middle-class backgrounds. Finally the different results may relate in part to the different research methods used. This research relies as much on interviews as on observational data. Interviews provide a way of accessing the criteria used by the staff when they make decisions related to patients' eligibility to care, and in so doing, they illuminate the factors that influence admission to the ED.

The present study suggests some new insights on the nature of categorisation. ED staff categorise patients and consequently accept, refuse or speed up the processing of presenting cases. Yet, in comparison with previous ED studies, the analysis of the rules used by the staff to build these categories shows that their behaviour cannot be interpreted only as deriving from the drive to 'professionalize' their occupation. Building on Elster (1992), I consider that staff created two 'local theories of justice' to allocate limited human resources in a way they perceived to be equitable. One is based on an egalitarian ideal (to give each patient the same service). Thus 'broad' doctors tend to admit all attenders. The second theory of justice is based on an ideal of equity (to give each patient the services s/he needs). Thus 'firm' doctors deny registration to individuals with benign problems. But people considered to be poor are less likely to be turned away. Taking into account the fact that this ED accepts a larger proportion of disadvantaged patients than most other public or private hospitals, these doctors formulate a new version of the public service ethos. The hospital's mission is not to welcome everybody and as a consequence to provide 'comfort medicine' to middle class patients; rather, it is to treat deprived patients who do not have access to care elsewhere.

Many ED doctors consider that this positive discrimination in favour of the socially disadvantaged, exempts them from criticism. They think that they have the right and the competence to judge patients' needs. However, this categorisation of patients leads to the micro-rationing of care because it is likely that some patients who have been re-directed will not obtain the equivalent service in another health care facilities. Some of them may even not see any doctor at all. Moreover, in searching for equity, doctors sacrifice the ideal of impartiality, according to which different people receive equal treatment according to need. Many ethicists argue that where differing treatments are provided for different groups, this should be based on principles which are applied consistently to everybody (Elster 1992). But in this ED, a person with a given non-urgent condition who is registered one day, could be refused the day after, according to such factors as the doctor in charge, the number queuing in the waiting room, and the interpretation made of his or her social situation.

The underlying conception of distributive justice recognised in this setting is negotiated between various actors, who have more or less legitimate authority to fix the rules. The reception clerk is not authorised to determine patients' eligibility. When she detects certain characteristics in the case of the presenting person, she has to call for a nurse or a doctor, who will decide whether to accept the attender or not. She has more room for manoeuvre in determining patients' order of precedence. Some nurses take responsibility for making decisions to accept patients, but most ask the doctor to make the decision. Where nurses take on this role, it is often because they are working with doctors who have indicated their willingness to delegate this task to the individual involved. Only doctors can decide which models of local justice will be taken into account. Two distinct models can be distinguished in this ED because two groups of doctors with the same hierarchical status disagree on what to do, and a senior consultant (who is distanced from the daily life of the

ED) allows them to determine policy on a case-by-case basis. This research shows that our understanding of the patient categorisation process must not be limited to the study of the interactions between would-be patients and the reception staff. It must be backed up with the analysis of power relations between staff members, who elaborate, fix and change the local informal rules in a dynamic process.

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Notes :

1. The exception may be patients who have vouchers for free care. Local Authorities distribute these vouchers to low-income residents deemed eligible, but some independent practitioners do not accept payment with vouchers.
2. The reception clerks are employees of the Admissions Department, which administers the recovery of patient invoice charges. Four members of staff share this job every day from 07.00 to 23.00 hrs. They are all young and have a limited education. Their professional status is lower than that of other hospital civil servants, they are on fixed-term contracts, in some cases part-time, and their wages are low. Three of them are women. Two of them live in the social housing blocks surrounding the hospital. 18 months into the study, two of the four had moved to other clerical posts in the hospital.
3. The medical team includes a consultant in charge of the Department, three other senior doctors ('praticiens hospitaliers'), four doctors equivalent to Senior Registrar ('médecins assistants'), four general practitioners who work part time in the Emergency Department and three Health Officers. The turn-over is high (on twelve doctors working in this unit in 1997, only five still worked here one year after).
4. This is from 'loi du 31 juillet 1991 portant réforme hospitalière'. See also the 'Circulaire du 21 mars 1995 relative à l'accès aux soins des personnes les plus démunies' du Ministère des Affaires Sociales. See also the 'Code de la Santé Publique' (article L711-4) which mentions that 'hospitals are open to every individuals whose condition requires their service. They must be able to welcome them night and day, if necessary urgently'.
5. These data are supported by the findings of social scientists studying other French street-level bureaucracies, such as Family Allowance Departments (Dubois, 1999) or Social Housing Offices (Weller, 1998a), which show that, against the background of the economic crisis of the 1990s, civil servants often exercised discretion to favour deprived people. These sociological studies also underline the fact that the analysis of public sector work and the public service ethos needs to be placed in a wider social and political context (Weller, 1998b).

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